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ABSTRACT

Focusing on the role and process of planning in the delivery of mental health services to the Mexican American community in Texas, this monograph examines the nature, context and purpose of planning; analyzes the interplay between federal and state mandates for planning; and assesses the status of current community mental health centers' (CMHCs) planning activites. A study of selected CMHCs and their respective planning systems examines their planning policy, structure, nature of planning, and relationship to other planning functions. A synopsis of the planning process at the Bexar County and Tarrant County CMHCs is provided. The following topics are discussed: culturally relevant service delivery; role of planners; a participatory model of planning; state plan requirements of Public Law 94-63; national guidelines regarding planning; the Connecticut and New Mexico mental health authorities' state planning activities; Texas' dynamic planning process; state planning and its relationship to service delivery to Mexican Americans in Texas; and the scope and level of citizen participation in planning, particularly Mexican American input into the process. The future development and impact of mental health planning is evaluated in light of current and potential changes in the community mental health system of Texas and the nation. (NQA)

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Mental Health Planning In Texas: The Impact On Mexican American Service Needs

by

Rosa Maria Moreno, M. Ed.

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ABSTRACT

The Mental Health Research Project (MHRP) has been engaged over the past three years in the study of the Texas community mental health system and its relationship to the delivery of mental health services to the Mexican American community. The MHRP was funded through a grant by the National Institute of Mental Health to conduct descriptive, systematic and evaluative social policy research through the use of archival, primary data-gathering and secondary data analysis techniques. The MHRP's major purpose was to focus its research efforts on such policy issues as utilization of mental health services by Mexican Americans; planning, treatment and staffing issues related to service delivery to Mexican American clients; and representation and participation of Mexican Americans in the planning, budgeting and decision-making processes of the Texas state and community mental health system.

This monograph centers on the role and process of planning in the delivery of mental health services to the Mexican American community in Texas. The author examines the nature, context and purpose of planning, analyzes the interplay between federal and state mandates for planning, and assesses the status of current community mental health centers' (CMHCs) planning activities. A comparison is made between planning concepts, processes, and methodologies being utilzied in selected CMHCs in Texas, and an analysis is made of their impact on mental health services delivery to Mexican Americans. The scope and level of citizen participation in planning, in particular Mexican American input into the process, is also discussed. The future development and impact of mental health planning is evaluated in light of current and potential changes in the community mental health system of Texas and the nation.

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MENTAL HEALTH RESEARCH PROJECT OF THE INTERCULTURAL DEVELOPMENT RESEARCH ASSOCIATION

The Intercultural Development Research Association's Mental Health Research Project (MHRP), funded by the National Institute of Mental Health, seeks to improve mental health delivery systems for Mexican Americans in the state of Texas.

The MHRP's major goals include: 1) a preliminary analysis of the effectiveness of the state mental health service delivery system and subsystems in providing services to Mexican Americans; 2) an assessment of the community mental health center concept as it relates to the Mexican American population; 3) the design of a bilingual/multicultural human service delivery model relevant to the mental health needs of Mexican Americans in Texas; and 4) the development of policy and programmatic alternatives to enhance the utilization of the state mental health service delivery system by Mexican Americans.

The MHRP has established a Texas Advisory Committee which consists of mental health service deliverers, professionals/academicians and consumer representatives from the five major geographical regions of Texas. The committee members serve as conduits for information dissemination and collection. To ensure maximum generalizability of the process and products of the MHRP, six nationally recognized professionals in the area of mental health and service delivery systems serve as consultants to the MHRP in the form of a National Advisory Committee.

The goal of the IDRA Mental Health Research Project is improved services for Mexican Americans in the state of Texas. Because a lack of agreement has existed in Census surveys and social science research as to the definition of a "Mexican American," potential problems emerge in attempting to compare data sources across regions or time frames. Terms encountered historically to identify this ethnic group include: Mexicans, Mexican Americans, Spanish-surnamed, Spanish-speaking, Latin Americans, Spanish Americans, Hispanics, etc. The term "Mexican Americans" is used consistently by the Mental Health Research Project to refer to this population, indicating those residents who are of Mexican origin or descent. References to specific data sources may at times utilize the exact label cited therein (e.g., "Spanish Americans"); it is assumed by the project that the overwhelming majority of any such individuals in Texas are of Mexican origin.

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CHAPTER I

MEXICAN AMERICAN MENTAL HEALTH: THE ROLE OF PLANNING

The primary reason for research interest in the area of planning as it relates to mental health services to the Mexican American community is to identify the extent and methods by which the needs of this special population are being developed. Coupled with this is the need to identify the point at which those interested in improving Mexican American mental health services can impact the current system with proposals, concerns, and policy recommendations. The importance of mental health policy research is most often found in the description and evaluation it offers of the mental health system, its components, and its practices. The descriptive methods used in policy research are useful in disseminating information regarding agency practices and their resultant outcomes (Kiesler, 1980). Such an approach is undertaken by this author regarding the planning systems being utilized by CMHCs and the impact that planning has had on provision of services for Mexican American mental health service delivery.

Understanding the planning and policy-making processes of the mental health system, whether it be at the national, state, or local level, is important in assessing the effectiveness of services to Mexican Americans, in that programs which are developed are usually strongly tied to the premises, policies, plans, and data bases on which they have been built. Any community mental health program may encounter considerable obstacles if it is implemented without sufficient information as to the size and characteristics of the population in the service area, the type and scope of service needs of this group, and the roles of family, transportation and other support mechanisms available. This is especially true for a population group that is culturally and linguistically different from the majority population for which such a program was developed.

The planning system, both for mental health and other human services, is by its nature subject to the political process. Planning implies a decision-making process made by one or more individuals which has as its intention the development and impact on programs, facilities, funds, and human resources. Planning decisions carry the potential of having a significant impact on the client population, as well as the community, as a whole. For this reason, it is essential that those affected by planning be aware of the process, understand its functioning, and have input at various stages of planning.

Mental health planning for community mental health services usually occurs as a result of politically-influenced action, whether this is reflected in the political decisions of a legislative body, the policy decisions of a board or administrator, or in the decisions of planners influenced by their personal political philosophies. The decision-making process in planning for mental health services, like so many other activities in public administration, is conducted in the realm of political affairs, i.e., "the competition between competing interest groups or individuals for power and leadership in a government or other group."[1] Within this reality, however, one must recognize the impact of other forces in planning, including the prevailing knowledge, beliefs, and innovations in mental health treatment, the prevailing social attitudes regarding mental health and mental health services, the private and public funding resources available, to name only a few factors.

Planning for mental health is most often intertwined with the federal and state legislative and regulatory processes, and therefore is especially subject to the pressures of the political climate of the current era. This is evidenced by the Reagan administration proposals, as well as by Texas legislative and state level planning. However, recognition of the importance and utility of planning has in recent years gained support in the human service field, primarily as a result of its implementation in the private business and industrial sectors of this country. Planning as an approach to resolution of current and future problems in a particular endeavor has been seen as a method for estimating, reducing and controlling costs, not only in terms of monetary costs, but also manpower costs and costs of time and resources as a result of errors or unanticipated events. Planning, in this sense, has been seen as a technological or scientific endeavor, a method by which to predict future occurences based on input information, and adjust one's activities depending on the outcome desired.

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[1] Webster's Dictionary, p. 657.

Planning as a field is a relatively untested and fertile field for innovation. As Hagedorn (1977) points out, there are no set of "proven techniques." In the area of human services planning, there is no extensive body of documentation in the history, research, or practical application in the planning field. To some extent, planning concepts have been borrowed from corporate planning and from scientific methodology.

Hagedorn (1977) contrasts the rational, abstract model of planning based on objectivity, data and analysis with the non-rational and more politically-oriented approach. Although the rational model in its ideal form is supposedly devoid of or above the realm of political influence and social pressures, the documents and plans derived in this manner, however independently developed and removed from the political and social process are ultimately accepted and respected in the reality of non-rational negotiative processes. The legislative and state agency planning processes are by definition influenced by the political and social processes of which they are a part, and are constantly subject to the scrutiny of public opinion and special interest groups. Proponents of the non-rational political approach view "the really important information as that which shows what is feasible, how to get things done, and how to put together the people necessary for a particular task" (Hagedorn, 1977, p. 1).

Implications for Mexican American Mental Health Planning.

Traditionally, Mexican Americans have not had a representative voice in decision-making, policy development, and the planning processes of our state and nation. Indications, such as the increase of Mexican Americans in the state legislature, give hope that this will change for the better in future decades. The majority of Mexican American citizens, however, have seldom been involved or had access to these processes. Increased political power and higher levels of public education in the future among Mexican Americans is likely to have a positive impact on this situation. However, at present the major reason for increased participation by Mexican American consumers, however limited, has come as a result of mandated requirements for minority and representative consumer participation on advisory and program committees. An extensive study of participation of Mexican Americans on Texas CMHC Boards and State Advisory Councils (Andrade, 1981) shows that such participation is still limited and is not highly representative of the Mexican American community as a whole.

As concluded by the Special Populations Sub-Task Panel on Mental Health of Hispanic Americans (1978) in its chapter on the "Mental Health Status of Hispanic Americans":

> "What is called for instead [of increased spending] is the rational and enlightened planning needed for an equitable allocation of existing resources, the elimination of inefficient approaches, and the maximizing of benefits relative to costs... such planning will be possible only if Hispanic Americans are allowed the opportunity to contribute in the shaping of future national policies and priorities respective to mental health."

Understanding the complex planning processes is not easy, even for the well-educated provider of mental health services; it is nearly incomprehensible for the average citizen and consumer. This monograph then is aimed at describing the planning processes for service delivery in the state and local mental health systems of Texas and to examine the relationship and appropriateness of these processes to the provision of culturally and linguistically-relevant services to the Mexican American community. In addition, an analysis is given as to the current level and adequacy of involvement of Mexican Americans in varying strata of planning services for mental health.

CHAPTER II

PLANNING: POLICY, PROCESS AND PRODUCT

As was mentioned in the previous chapter, the Special Populations Sub-Task Panel on Mental Health of Hispanic Americans of the President's Commission on Mental Health (1978) recommended that increased efforts in planning be initiated in order to address adequately the needs of Hispanics and that planning include the active participation of this significant ethnic group.

In addition, the President's Commission on Mental Health (1978) advocated an increase in the role that planning plays in the mental health service delivery process. With great emphasis being placed on the desirability of deinstitutionalization as a national priority, the Commission reported that "too often it has occurred without adequate planning" or without proper attention and preparation for the type of community-based services that are needed by the patient affected (Bachrach, 1979). Implied in this statement is the idea that any major policy, such as deinstitutionalization or culturally relevant programming, needs to be supported by sound and careful planning. What exactly is meant by planning is not well-defined, however, by either national study groups like the President's Commission on Mental Health, its Special Populations Sub-Task Force or by mental health legislation which addresses the issue of planning. A review of the various approaches, definitions, and conceptual models of planning, therefore, seem appropriate.

In very simple and ideal terms, planning can be seen as both an intellectual exercise and a skillful art. It involves reasoning processes -- analysis, synthesis, etc. -- as well as creative abilities such as the vision and imagination to picture what the future might look like under a certain set of circumstances. It involves the conceptualization of various methods or alternatives for accomplishing the same end and requires such practical skills as the ability to present and communicate ideas in a manner so as to be accepted, understood, and implemented by individuals, groups and/or organizations.

Planning in many cases is associated with the important considerations of policy development, policy alternatives, and policy implementation. As defined by Alfred Kahn "planning is policy choice..." or "policy formulation and realization through choices and rationalization" (Kahn, 1975).

Planning, however, is also a process by which to develop and implement programs and services based on policy considerations or policy guidelines. Planning as an activity is of great importance in the functioning of an organization. Whether administrators of an organization or program are consciously or systematically involved in planning, the decisions made by them have consequences for the future, often times consequences which cannot be reversed or easily modified. Thus, the conscious undertaking of planning serves to provide direction and guidance for decisions made today which will greatly affect the future years of a project, program, or organization. Planning can be compared to deciding the destination for a trip; knowing one's purpose for the trip is the first step towards determining the destination and many other details of the journey. Deciding between alternative courses is based on considering information on a variety of factors, such as the available routes, transporation methods, costs, etc. No matter what the ultimate decision made regarding arrangements for the trip, each alternative considered leads to a different goal, i.e., to a different set of consequences associated with the choice. As Littlestone (1973, p. 4) summarizes:

> Decisions made today that affect an organization's existence tomorrow are the substance of planning. The ability of an administrator to make sound decisions will depend upon his knowing what decisions are possible, the consequences of each, their impact on his organization,

> and which decisions, taking everything into account, are likely to move the organization most quickly and effectively in the direction it wishes to go to meet its objectives.

Planning is quite often associated with a product, e.g., a written document, a construction project for a center, or provision of a specific service. However, a written document or plan is in itself not a product but rather the documentation of policies, processes, and service delivery goals derived through planning activities. Planning can thus occur at various levels of abstraction or specificity: the policy level, the programming or operational level, and the implementation or service delivery level.

Howland identified three levels of decision-making in the planning process as exemplifying the various strata and settings in which planning occurs (O'Brien,.1975). The strategic level is concerned with policy decision-making, broad goal formulation and budgeting, while the operational level transforms the strategic-level decisions into programmatic components through operational planning. The third, or tactical level, of decision-making involves the routine day-to-day monitoring and planning of service delivery activities based on the program plans, activities which are usually the concern of the front line service workers and their immediate supervisors.

Planning is often associated with the term development, since it is seen as a necessary and essential step in the process of growth or movement towards a more positive, rewarding state in the future, whether growth is measured on the basis of economic, physical, or human potential changes.

One of the basic assumptions for any kind of planning is "that ordered change is possible" and that as a participant in planning, one can "have at least partial control over the variables which produce change" (Blum et al., 1969). In essence, before an individual can actually become involved in planning, he or she must adhere to the concept that social change can and does occur and that it can be influenced or directed by human action. This is not to say that all occurrences can be planned or that all events or changes can be controlled by humankind. Blum _et al_. (1979) present four approaches to planning for social change, which they propose are based on distinct philosophical roots and which therefore have differing implications for planning. The four approaches are: 1) the laissez faire approach; 2) the disjointed incremental approach; 3) the goal-oriented development process; and 4) total planning.

The laissez-faire approach consists of a "let things be" method, by which little or no planning or intervention is attempted, but instead the "natural state of things" is allowed to develop. It also is reflected economically by a belief in the competitive market and a belief in individual initiative and freedom to choose between alternatives in a competitive market system. The disjointed incremental approach refers to a piecemeal approach to problem-solving whereby decision-making occurs at various levels and often without any interrelationship or mutual influence. Ad-hoc planning, consideration of limited alternatives, non-comprehensive outlook, and short-range solutions are some of the characteristics of this approach. The goal-oriented development process, which Blum _et al_. advocate, is an approach which involves rational processes and citizen participation in combination. It includes assessment of needs and resources, analysis of problems, and goal development by means of community consensus. The process is oriented towards long-term plans with annual review, thereby allowing flexibility to re-assess goals based on new knowledge, changing resources, or unanticipated consequences. The total planning model involves a highly rational, expert, elitist approach in which all details are worked out in advance and followed strictly according to plans, therefore requiring a great deal of centralization and inflexibility.

In terms of overall planning for health services, Blum *et al*. consider the disjointed incremental approach to be the predominant planning force in the U.S. today, in that attempts at providing health services are largely left to the competitive market, with only limited attempts by society to plan in a piecemeal fashion the health needs of the nation through public health initiatives. In contrast, the goal-oriented approach would require a higher degree of coordination between private, competitive markets and governmental agencies in order to provide a more integrated system, and involving long-range planning with citizen consensus in the process.

Another analysis of the planning process for social service programs has been outlined in the following eight steps:

1. Goal identification;
2. Needs assessment;
3. Resource identification;
4. Priority setting;
5. Eestablishment of objectives;
6. Consideration of alternative approaches;
7. Program implementation; and
8. Monitoring and evaluation. (Salvatore, 1975)

A somewhat broader perspective is taken in Horton and Hoffman's description of the analytical steps in a state human services planning system. After identification of the human service requirements or needs, an analysis of the current programs or resources in human services is undertaken. After comparing needs to resources, the next step in the process entails the development of human service goals and objectives, based on any number of sources of input, including citizens, expert opinion, political and data sources. The last step in the planning process is the allocation of resources based on the goals and objectives formulated (Horton & Hoffman, 1975).

Another brief description of the steps in the planning process, as summarized by Kahn (1975), includes the following sequence of activities: "goal definition, formulation of possibilities, choices of policies, execution, and evaluation."

Definitions of Planning.

McCurnin (1974) reviews the various definitions of planning which have been posited in sociology, economics, management, urban planning, and other fields. Most definitions emphasize the component of process, i.e. that planning is a process by which one achieves certain goals or ends through a rational, systematic method of decision-making. It is a method or process of preparing for and affecting the future. The sociological perspective of planning acknowledges the intervention or involvement of social values in the process, while the economic view points to the importance of quantification and time-specificity in planning for economic development goals. Planning is also defined by some theorists in terms of a public activity, with an objective of promoting or achieving public and community interests.

McCurnin's own views are summarized in a definition of planning which encompasses the flexibility of plans, i.e., that "plans are hypotheses ...and should not be fixed, static ideas that cannot develop or adapt over time." Rather planning is seen as a continuous, even cyclical process, but never as a completed process where one arrives at a final product -- a plan -- which is final and not subject to revision (McCurnin, 1974, p. 29). The involvement of the community as actors or planners in the planning process is expounded in Ross' definition of social planning as a process in which the community seeks to identify and resolve its own problems through identifying actions needed to deal with these problems (McCurnin, 1974, p. 32). A somewhat different approach is taken by Fitch in his definition of social planning or planning of human services. He sees planning of this type as a primarily governmental function aimed at achieving social change in terms of economic, cultural and social development of certain subgroups of the population (McCurnin, 1974, p. 32).

An important aspect of planning which should be recognized is the intent of planning itself: the defining and mapping out of expected ends or actions. A plan spells out what is expected to occur and what behavior, resources and strategies will likely be needed to achieve certain outcomes. It is not simply a documentation of what an individual, an organization or a community intend to do or what may occur as a natural process of the status quo. In this sense, planning involves change and, moreover, an active involvement and concerted effort to achieve the goals or outcomes expected as a result of the planning process.

Participatory Model of Planning.

More recent approaches to planning, especially human services planning, have attempted to incorporate a participatory model of planning. This model encourages the participation in the planning process of individuals, groups, and other entities which are likely to be affected by the decisions and policies of the planning process. Such participation, according to this perspective, enhances the likelihood that plans will reflect shared goals and common interests, and that greater support can be expected of the various entities towards the achievement of planning goals. With the passage of the 1963 Community Mental Health Centers Act (P.L. 88-164), the federal government began to adopt the concept of participatory planning with regard to state planning for mental health (Hagedorn, 1977). As discussed in

Chapter I, the participatory model of planning has been contrasted with rational data-based approach, and in recent years, federal emphasis has shifted towards inclusion of a balanced planning system, which incorporates both approaches.

The more traditional model of planning as an intellectual activity, a rational data-gathering method or a policy selection and decision-making process, does not usually include participation of those affected as a high priority. It may not even attempt to address factors which may be of importance to those impacted by planning decisions, because planners operating in this mode may not be aware of what these factors are or they may not place as a high a value for their consideration. Plans developed using this approach may end up being a futile exercise, since they may encounter opposition in the long run, may be considered unrealistic, or may have been based on false premises or lack of adequate data (Littlestone, 1973).

Participation of a wide spectrum of community members in the planning process is seen as a positive value by some individuals, since it often leads to a greater consensus about community goals for the future. However, participation of a broad representation of the community does not necessarily lead to consensus and, in fact, may accentuate the differing values, needs and priorities of various groups in a community. It is for this reason that there is criticism of appointed or selected members to boards and advisory committees who, because they are members of a particular ethnic group, are seen as autmomatic and able representatives of the needs and interests of that ethnic group, in part or in its entirety.

Regester (1974) identifies the concept of "community" and its definition by CMHC staff as a crucial influencing factor in the direction that mental health programming may take in a CMHC. "Conceptual-theoretical planning should precede mental health programming, rather than develop erratically or not at all from analyses of the programs implemented by a CMHC." A clear concept of how the CMHC staff define "community" is a prerequisite, in his view, for the development of mental health programs in that "community." He develops a schema of eight explanations or descriptions of the concept of community which might be adapted by a CMHC:

1. Geographical area;
2. Majority of populace in a region;
3. Vocal Minority, as political pressure demands;
4. Society-at-large;
5. Common body of people identified by attitudes, beliefs, economic or political identities;
6. Feeling of belongingness. Community defined by facilitation of individual differences;
7. Elitist - those individuals/groups which staff decides to serve by unintentional selection; and/or
8. Community defined by the type of mutual interrelationships, such as personal, caretaker, professional; excludes state hospital penitentiary and other institutions as "out of the community."

Register (1974, p. 889) further elaborates on the importance of needs identification in relation to a specific concept of community:

> Any comprehensive community mental health endeavor requires a degree of depth and breadth of awareness of community needs in order to optimize program effectiveness. Critical to community mental health programming, therefore, is an assessment of community concerns, problems, needs and system interrelatedness.

One method of developing community participation in the planning process involves identifying a liaison person from the community or an indigenous professional who is on the CMHC staff. This individual's role is to set up preliminary meetings with community organizations and other interested individuals and to solicit ideas regarding overall community needs. From these meetings, a community advisory board for the CMHC can be developed. At this point, the planners and administrators can be introduced by the liaison person, and together a delineation of specific mental health needs can be undertaken (Harris, 1972).

In the past, those served by public agencies have had little control over the type or quality of service provided them. A contributing factor to this paradox has been the lack of public support or identifiable constituency groups which clients could rally on their behalf. The only form of control which consumers of human services were able to exert was through their own action, by either rejecting or undermining the services provided. Mexican American mental health clients are a vivid example of this phenomena, in that they have consistently underutilized services in the past or rejected portions of the entire service delivery system.

The form the consumer participation takes is as important as its existence per se. It should involve, according to Zamorano-Gamez & Carsman (1978) not only a mechanism by which a community's voice can be heard in the decision-making and policy development process for planning and implementing services for that community, but also the inclusion of delegates of the various constituencies and consumer groups in that community who would represent community needs, approving and rejecting policies and programs, and inform and solicit input from their respective constituencies on decisions or proposals being considered.

Although consumer participation in more recent times was introduced through P.L. 89-749 in 1966, when comprehensive health planning agencies were established, there was no significant impact, especially on minority groups until the passage of the Community Mental Health Amendments of 1975 (P.L. 94-63) which mandated that governing boards of a CMHC as a whole be representative of the residents of area, especially with respect to occupational, age, sex, and other demographic characteristics. At least one half of the members of the boards were to be individuals who were not health care providers. The language of P.L. 94-63 has encouraged more consumer participation, but as Andrade (1981) documents, for Mexican Americans in Texas, representation on CMHC boards is still far from adequate.

Andrade (1981) also summarizes research which documents that for those representatives of the community of whatever ethnicity who have managed to find themselves appointed to boards, their efforts often meet with frustration because of lack of experience or expertise or because of the complexity of the system itself. Patronizing attitudes of professionals and administrators or citizen input that runs counter to a center staff's own opinions usually result in lessen enthusiasm for the consumer's input.

Harris (1972) argues that community involvement in the development of a community mental health center is looked upon with distrust by most urban minorities, based on their past experiences with public institutions. The history of active involvement of the poor and uneducated in the planning of services for their community has not been a long one. At best, the past two decades' experience with anti-poverty programs have been able to organize some citizen involvement, fragmented as it might have been. Harris attributes part of the community participation elicited by the poverty programs to the fact that individuals could see the fruits of their efforts in more immediate and tangible ways, e.g., jobs and economic development projects. With the CMHC programs, the immediate benefits are not so visible. Harris also suggests that the CMHC will be more effective, both in addressing community mental health needs and in encouraging citizen input, if planning involves the community's overall needs. If the CMHC can participate in stimulating resources to meet other basic services and needs of the community, it will be serving its mandate, as well as gaining credibility as a helping institution in the area.

One method of obtaining citizen input which seems to be popular among community mental health centers nationwide is the consumer satisfation survey. Sorenson et al. (1979) reported that 173 (48%) of the 366 CMHCs they surveyed had conducted some type of consumer feedback evaluation within the past two years and that many other centers planned to initiate surveys in the near future. The information derived from consumer satisfaction surveys is usually beneficial only as documentation for funding sources or the local board of the effectiveness of services or programs. Nevertheless, there are conceptual and methodological problems with such measures, in particular the fact that a center receives no information on needy individuals who do not come in for services. Furthermore, the results are seldom reported back to the community or to the client population.

Planning services for any community "must take into account prevailing community attitudes and potential motivations" (Angrosino, 1978). Research conducted in one community by Angrosino on community, staff and consumer attitudes toward a mental group home demonstrated the necessity of including community involvement and education about services as part of the early stages of the planning process. Community acceptance and utilization of services often hinges on local understanding of the goals and methods of the program. If this information can be communicated early in the development of program misconceptions and community opinions based on misinformation are less likely to hinder the service delivery process.

Community responses to mental health and mental retardation programs can be categorized into four basic types: 1) the anti-participation role, where the agency or project is seen as an intruder and is therefore rejected by the community; 2) consumer response in which the services are perceived by residents to be of benefit to the community and themselves; 3) the franchizer response, in which the community sees the agency as external to itself, essentially existing in but not for the community in order for one group to provide a service to another group; and 4) the sponsor role, where the community participates in contracting for or supporting the program (Angrosino, 1978).

Functions and Roles of Planners.

Various factors influence the endeavors of planners and consequently the type of planning activities that they initiate. Among these are the personal attributes and values of the planner, the type of skills, training and previous experience of the planner, and the resources and support available to them (Lauffer, 1975). Other factors also play a role, such as the sophistication of the existing data system from which planners must draw for information and the planner's ability and inclination to utilize such information in his or her planning strategy. The socio-political and organizational framework in which the planner must carry out his duties and responsibilities also has great bearing on the type of planning that is implemented. Lauffer (1975) proposes that planners generally perform three basic functions in direct service agencies:

> 1) mobilization of support for the agency's ideology, program, or financial needs; 2) guidance for the process of interorganizational exchange of such resources as personnel, specialized expertise, facilities, funds and influence; and 3) direction of agency efforts at changing community resources and programs outside the direct jurisdiction of the agency itself but necessary to the welfare of its clients and constituents. (Lauffer, 1975, p. 53)

The personal skills of the planner, such as his or her ability to use certain type of survey techniques, expertise in understanding and manipulating social indicator data, or ability in community organization and advocacy, can to a great extent determine the type of tools and the method of planning the individual will initiate or emphasize with an agency.

Two pitfalls which planners may fall into are those of concentrating too much on data gathering and comprehensiveness of information available to them for planning that it may lead to either very general, idealistic goals which may be partially or wholly unattainable or may result in developing goals which are not action-oriented. The planner in effect may become so involved in the data collection and analysis process that he or she never addresses the implementation segment of planning.

The kind of formal and informal training and skills which planners possess are often a crucial factor in their level of effectiveness and credibility with the various groups and individuals they must work. Among some of the basic skills necessary are analytical, negotiating and decision-making skills (Lauffer, 1975). Human relations and interactive skills are also of prime importance, as are organizational, political, and social planning theory. Knowledge of community organization, data analysis techniques, and administrative ability are also significant assets in planning. Perhaps the significant criteria is a thorough understanding of the purpose, goals, theoretical framework and practical application of the service delivery process for which planning is being undertaken, whether it be health services, mental health, planning, or some other human service delivery system.

Relevance for Culturally Appropriate Service Delivery.

The various conceptual schema, definitions and role prescriptions for planning point to the importance of studying the mental health planning system and its response to issues of culturally appropriate services for Mexican Americans. Not only must one consider national, local and state policies and their impact on the quality and effectiveness of mental health services to Mexican Americans, one must also consider the intent, execution and impact of planning activities undertaken by administrators and staff in the state mental health system and in community mental health centers. To a great extent, the policy level planning being undertaken should be reflected in the program and implementation level planning being carried out at the regional and local levels. As has been pointed out, the roles and value orientations of the administrator and planners involved are often important factors in the scope and effectiveness of the planning process. In addition, the inclusion of Mexican Americans in the various levels of planning is essential to the adequacy of effectively planned programs for Mexican American mental health needs. Whether attempted through a participatory model of planning, a strictly rational-based approach, or a combination of the two, Mexican American involvement is a factor to consider in determining the successful accomplishment of culturally relevant programming.

CHAPTER III

THE MANDATE FOR MENTAL HEALTH PLANNING

The federal government's expanded role in the mental health delivery system did not actually emerge until after World War II, with the Congress' passage of the Mental Health Study Act of 1955. This established the Joint Commission on Mental Illness and Mental Health, which made sweeping recommendations for the development of services in local mental health clinics and general hospitals as alternatives to those in large state mental institutions which predominantly cared for the mentally ill at the time. The recommendations were finally embraced by the U.S. Congress in the passage of the Community Mental Health Centers Act of 1963, with the strong push and support of President John F. Kennedy. In a sense the Act made necessary for the first time the assessment of local mental health needs. In addition, the thrust of the Act made "comprehensiveness" of services an important aspect of providing local mental health services. It also emphasized the development of prevention services and the catchment area concept as a means of identifying the local community for which services were to be provided.

Congress authorized grants to the states to develop comprehensive mental health plans as early as 1962. It was with the aid of federal appropriations that Texas and many other states developed their first State Plan for Mental Health Services.

With the passage of the Community Mental Health Centers Act of 1963 and its subsequent amendments, federal financial support was provided for construction of center facilities and for assistance in staffing the CMHCs created under the Act.

The construction grants were dependent on fulfilling certain requirements, a primary one being the development of a state plan for identifying and prioritizing the areas of the state most in need of centers for community mental health (International Encyclopedia of Psychiatry, Psychology, Psychoanalysis and Neurology, pp. 250-253).

The Mental Retardation Foundation and Community Mental Health Center Construction Act (P.L. 88-164, Section 204) required that each state in order to receive funds under the Act, submit a plan to the federal government for mental health services. Catchment areas were to be designated by each state in their state mental health plans in the 1963 federal mandate. States were also required to submit to the federal government state plans for approval in order that applications from within their state for community mental health centers (CMHCs) could be considered. A further requirement was that CMHCs were to provide services in a non-discriminatory manner (Kuramoto, 1977).

The National Health Planning and Resources Development Act of 1975 (P.L. 93-641) significantly impacted the level of health and mental health planning activity which was required by federal mandate.[1] This statute required comprehensive health planning, which was interpreted to include mental health services planning.

State Plan Requirements of Public Law 94-63.

The Community Mental Health Centers Amendments of 1975 (P.L. 94-63) addresses the issue of planning for mental health services more specifically than any other previous legislation. Following previous precedent, Title III of P.L. 94-63 required a State Plan for comprehensive mental health services of each state in order for CMHCs to be considered for funding under the Act. However, this Act contained many more stipulations, ranging from fiscal management specifications to bilingual services, and included an increased emphasis on state and local level planning and citizen involvement (Kuramoto, 1977). P.L. 94-63 also provided for grants to be awarded to CMHCs for planning.

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[1] For a detailed analysis of this legislation, please refer to Sepulveda-Hassell, 1981.

P.L. 94-63 required the state mental health authority (which in Texas was the Texas Department of Mental Health and Mental Retardation) to: 1) describe annually the comprehensive mental health services provided by the State for the year in which grant application was made; 2) establish and carry out a plan to eliminate inappropriate placement in institutions, provide for appropriate non-institutional placement, and improve quality of institutional care; and 3) prescribe and enforce minimum standards for maintenance operation of mental health programs and facilities.

Provisions of this federal law required the State Plan to include an administrative section and a services and facilities section. The administrative provisions amounted to a report describing compliance with the provisions for appointment and operation of a state advisory council to the state mental health agency, assurances of the state agency's compliance with the Department of Health, Education and Welfare reporting requirements (including the submission of a report on the annual review of the State Plan) and a description of the state agency's provisions for a merit system within its personnel policies.

The services and facilities portion of the State Plan was to address the services to be offered within the state by CMHCs and the facilities to be utilized by the centers for service delivery. The State Plan for mental health was to be consistent with the sections of the state's health plan relating to mental health services, as prepared to comply with the Public Health Service Act, under provisions of Section 1524(c)(2) or Section 314(a), as applicable.

The specific provisions required in the services and facilities section of the State Plan were as follows:

> (B) set forth a program for community mental health centers within the State (i) which is based on a statewide inventory of

existing facilities and a survey of need for the comprehensive mental health services described in section 201(b); (ii) which conforms with regulations prescribed by the Secretary under section 236; and (iii) which shall provide for adequate community mental health centers to furnish needed services for persons unable therefore;

(C) set forth prescribed under section 236, for the projects included in the program described in subparagraph (B), and, in the case of projects under part C, provide for the completion of such projects in the order of such relative need;

(D) emphasize the provision of outpatient services by community mental health centers as a preferable alternative to inpatient hospital services; and

(E) provide minimum standards (to be fixed in the discretion of the State) for the maintenance and operation of centers which receive Federal aid under this title and provide for enforcement of such standards with respect to projects approved by the Secretary under this title. (P.L. 94-63, 1975)

Foreseeing the need for careful and systematic development of community mental health centers, the lawmakers included in Section 202 of P.L. 94-63 provisions for application for planning grant funds by public and non-profit private entities for the development of CMHC programs. Any project funded was required to: 1) assess the needs of the area for mental health services, 2) design a community mental health center program for the area based on such assessment; and 3) obtain within the area financial and professional assistance and support for the program, and initiate and encourage continuing community involvement in the development and operation of the program.

The maximum amount granted to any project was set at $75,000, and the authorization amount in P.L. 94-63 allowed for at least 50 projects each year in 1976 and 1977 to be funded nationwide.

Grants under P.L. 94-63, Section 203, for initial operation of a CMHC were required to provide the 12 essential services, or provide a plan to the Secretary of DHEW for providing these services within two years after the receipt of the initial grant. In addition, grants could be awarded to a CMHC only if an approved State Plan had been submitted to DHEW, which met all the requirements of Section 237 of the Act.

Centers receiving grants for initial operation for consultation and education, or conversion grants under the funding authorized by P.L. 94-63, were required to provide: 1) an overall plan and budget that would meet the requirements of Section 1861 and of the Social Security Act, and 2) assure that an effective procedure was operational in the center for gathering, maintaining and evaluting statistics which would be reported periodically to DHEW. The statistics consisted of data on the center's operational costs, its service utilization patterns, the availability, accessibility, acceptability, and impact of services on residents of its service area. The general provisions of PL 94-63 also emphasized the need for CMHCs to involve area residents in the review of its services and programs.

Two other planning requirements in P.L. 94-63 were: 1) a financial support plan to address financial resources to be tapped as federal support diminished, and 2) long-range plan for expansion of the center's services in response to future projected demand for comprehensive mental health services by residents of the service area. The plan was to include: 1) a description of planned growth in the programs of the center; 2) estimates of increased costs arising from such growth; and 3) estimates of the portion of such increased costs to be paid from Federal funds and anticipated sources of non-Federal funds to pay the portion of such increased costs not to be paid from Federal funds.

An interesting requirement included in P.L. 94-63 was the stipulation that a program of on-going evaluation of program effectiveness as it relates to community needs, as well as quality review program, be provided by the center, by obligating an amount equal to at least two percent of its previous fiscal year's operating expenses.

P.L. 94-63 was specific as to the response that centers were to make in planning for services for limited English-speaking populations in their respective catchment areas. It required the development of a plan for services for such a population subgroup that would demonstrate responsiveness to its needs, and the provision of services in the language and cultural context most appropriate to such individuals.

National Guidelines Regarding Planning.

Aside from national legislation requiring mental health planning at the state and local level, the national and state standards developed for public mental health services funded through federal, state and regional sources also provide guidelines and set minimum components for planning.

The National Standards provide specific criteria for development of a comprehensive service plan for each community mental health center (CMHC). The standards describe three types of assessment approaches which can be used as methods for determining quality of care and developing standards: assessments of structure, assessments of process, and assessments of outcome. The National Standards for CMHCs, although a combination of these three approaches, places a greater emphasis on the structural assessment criteria. The structural approach focuses on the organizational features and prerequisites necessary for providing quality care, while the process approach is designed to assess activities of care providers to determine if such activities constitute good care. The outcome approach uses as standards of measure criteria related to the results of the treatment given, especially from the perspective of the client's health status and satisfaction with services. The fact that the national standards favors the structural approach is reflected in the criteria by which planning standards can be judged as met by CMHCs.

The standards and criteria of assessment for development of a comprehensive plan of services by a CMHC, as delineated in Section II of the standards (Program Administration), is provided below.

A Comprehensive Plan of Services

Standard

> There shall be a Comprehensive Plan of Services which is updated at least annually to reflect changing needs. The Plan shall include the following:

Criteria

A. A description of the community to be served in terms of demographic, geographic, and economic data, using already existing data whenever possible.

B. A description of the human services system serving the target population, including social services, public health services, visiting nurse services, rehabilitation services, employment services, sheltered living arrangements, services of private agencies.

C. Estimates based on available data of the types and extent of significant social, health, and mental health problems in the community including estimates of the types and extent of emotional and substance abuse disabilities in children, adolescents, adults and elderly.

D. A description of existing services dealing with the problems estimated in C including an evaluation of the degree to which the services match the estimated needs.

E. A projection of the amount and type of Center services needed to adequately serve the unmet comprehensive mental health needs of the service population as described in D.

F. A description of the purposes, goals and objectives of the Center.

G. A description of how, when, and where proposed programs described in F will be implemented including the methods to be used, the projected costs, and the means of financing.

H. Where proposed programs are to be provided through affiliations with community agencies, the authorities and responsibilities of the Center vis-a-vis the affiliating agencies must be clearly spelled out in writing.

I. A description of the hours of operation of the various services.

J. A description of efforts to assure accessibility and availability of services including arrangements for making services available to those in nursing homes, jails, etc.

K. A description of working relationships with other health and mental health facilities serving the catchment area.

L. A description of working relationships with other human service agencies (those described in B above) serving the catchment area.

M. A description of working relationships with health planning and other relevant planning agencies.

N. A description of the means for assuring citizen and client input to program planning (NIMH, 1977).

The Standards also outline requirements for centers to maintain both a program evaluation component and a quality assurance program.

Mental Health Planning Requirements in Texas.

The only references to the development of planning for mental health services under House Bill 3, the Texas Mental Health and Mental Retardation Act, as amended, are those found in Article 5547-204. It requires submission of a plan to the TDMHMR by each community mental health center as soon after its establishment is possible; the plan submitted should project the financial, physical and personnel resources of the region to be served. The implementing guidelines for this mandate for community mental health planning are described more fully in two important TDMHMR documents: The Principles and Standards for Community Mental Health Centers; and the Rules of the Commissioner of Texas Department of Mental Health and Mental Retardation.

In The Principles and Standards for Community Mental Health Centers, the board of trustees of each center is responsible for reporting "annually to the sponsoring agencies on the Center's progress, needs and goals" (Texas Department of Mental Health and Mental Retardation, 1978b). A guiding principle has also been established that requires the board of each center to "maintain an annual and long-range comprehensive service plan which specifies needs and objectives in program areas (Texas Department of Mental Health and Mental Retardation, 1978b). The accompanying standard states that the board shall require "a comprehensive service plan describing community needs and target population which is reviewed and updated annually" (Texas Department of Mental Health and Mental Retardation, 1978b). Provisions for ensuring that the service plan of the center is followed is left up to the authority of each center's board. The standard mandates that quarterly reports of the center's operations in each program area be required of the center staff by the board, and that these reports include as minimum data on the quantity of services provided, any deviation from the goals in the service plan, and any change in the implementation of the center's programs. In addition, the board is required by the standards to monitor quarterly unit costs of services and to review budget expenditures and revenues of the center on a monthly basis. (Texas Department of Mental Health and Mental Retardation, 1978b).

The Comprehensive Service Plan which each center must develop is required to address the following services, in addition to any others the board may choose.

- screening of residents being considered for admission to state residential facilities;
- emergency services;
- outpatient services;
- therapeutic and rehabilitative services aimed at maximizing independent living in the community;
- transitional and long-term residential services;
- twenty-four (24) hour intensive treatment services (inpatient services for persons who cannot cope successfully with their communities or who are dangerous to themselves and others.
- services to meet the mental health and substance abuse needs of children, adults, elderly. (Texas Department of Mental Health and Mental Retardation, 1978b).

The State Standards also require that each center maintain a Quality Assurance System to assure that a mechanism exists to determine if standards are met and to recommend needed improvements in service delivery. The stipulation in the State Standards regarding development of a comprehensive service plan follows closely the requirements set forth by the federal legislation.

In addition, to the requirement that a CMHC maintain an annual and long-range comprehensive service plan which specifies community needs and a description of the target population, the Principles and Standards also state that the center minimize social and cultural barriers to receipt of services by having bilingual/bicultural staff and materials as appropriate to the service area, and that all staff be familiar with the culture of the major population subgroups in the service area. (Texas Department of Mental Health and Mental Retardation, 1978b).

The Rules of the Commissioner (Texas Department of Mental Health and Mental Retardation, 1976b) governing community mental health centers was published by the Department in January 1976. These Rules require that a plan be submitted to TDMHMR by each board of trustees established after the effective date of the rules (Rule .002). New CMHCs developed after the Rules were approved are required to submit a plan for mental health and mental retardation services to the residents of the area. The plan is to consist of: a description of the catchment area, in terms of the physical, financial, and personnel resources; the extent to which other services agencies in the community were involved in the planning of services by the new CMHC; the long-range service goals of the center; and the cost of the services being proposed. Centers with a functioning board of trustees prior to the promulgation of the Commissioner's Rules are only required to submit annual plans describing proposed activities for the coming year. The Rules also indicate that a center's planning process is required to take into account the social, cultural, and economic factors of the population in its service area.

The Texas Department of Mental Health and Mental Retardation State Plan for Comprehensive Mental Health Services (Texas Department of Mental Health and Mental Retardation, 1976a) also makes reference to the need for responsiveness to community needs and values and to relevancy in meeting the individual client's treatment needs. The Plan outlines the TDMHMR Philosophy of Treatment and Care, which incorporate the following four principles:

a. The TDMHMR's care and treatment must focus on client's needs.

b. The system must take positive action not to abridge the rights of clients.

c. The system must assure that clients receive "high quality care."

d. The delivery system must be responsive to community values and attitudes when designing programs and delivery systems (Texas Department of Mental Health and Mental Retardation, 1977).

Planning Services for Minorities.

The Report of the President's Commission on Mental Health (1978) pointed out that any attempt at defining and assessing mental health problems must consider the contribution of such factors as poverty, unemployment and institutionalized discrimination based on race, ethnicity, and sex.

This recommendation by the Commission had to some extent already been addressed by the Congress in drafting the Community Mental Health Amendments of 1975. The amendments had sought to assure that the special concerns of discriminated minorities were addressed by CMHCs in their planning by requiring citizen input that was representative of the service area, by stipulating that programs and services reflect the needs of the community being served, including population sub-groups, and in the case of the limited English-speaking and culturally distinct minority, CMHCs were to plan for appropriate staffing and programming in the delivery of services.

Aside from the national legislation, and the national and state standards mentioned, there are several other documents which provide some guidelines for planning and which specifically address the planning process as it relates to the services for the Mexican American client. Foremost among them is The Report to The President's Commission on Mental Health from the Special Populations Sub-Task Panel on Mental Health of Hispanic Americans (1978) assessed the limitations and problems in current approaches to research and service delivery for Hispanic communities. The Hispanic Panel made several recommendations which relate to various elements of planning. For example, it saw the need for data-gathering efforts to be coordinated among federal agencies, and for statistics collected by these agencies to include ethnic breakdowns in order to determine demographic and epidemiological characteristics of Hispanics and major Hispanic subgroups, such as Mexican Americans, Puerto Ricans, and Cubans. The Panel also found that data on incidence and prevalence of mental illness in Hispanics were practically non-existent and that epidemiological research efforts needed to be funded at all governmental levels. Without such basic knowledge, the Panel's members noted that planning appropriate and needed services for the Hispanic becomes a matter of intuition, creative deduction, and sheer guesswork.

CHAPTER IV

MENTAL HEALTH PLANNING AT THE STATE LEVEL

The federal promotion of state planning for mental health services which was initially begun in 1963 with the passage of the Community Mental Health Centers Act (P.L. 88-164) has been actively strengthened in recent legislation, most notably the National Health Plan and Resources Development Act of 1974 (P.L. 93-641) and the Community Mental Health Centers Amendments of 1975 (P.L. 94-63). The requirements of these legislative mandates for planning have led to the establishment of an annual system of mental health planning at the state level. The legal framework, however, has provided significant support for a community-based and participatory-oriented planning system. A manual for state mental health planning prepared through a contract by NIMH emphasizes this approach and introduces guidelines by which local level input and consensus can be incorporated into a statewide comprehensive approach to mental health planning, which integrates the traditional state institutional structure with community-based services (Hagedorn, 1977).

Although the rational, analytical approach to planning is not rejected or set aside by the current federal regulations on planning, the emphasis on rational planning approaches has been so great in the past that a participatory approach is now being promoted in order to achieve some balance or integration in the planning approaches used.

State Planning Activities of the Connecticut and New Mexico Mental Health Authorities.

One state's response to the need for statewide planning of mental health services is exemplied by the Connecticut Mental Health Planning Project (Pedersen *et al*., 1973). The Connecticut project was successful through state legislation in establishing regional mental health planning councils, whose major responsibility is to review funding applications regarding mental health services and to make recommendations to the state's Commission of Mental Health. Although the State was authorized to make the ultimate decision on any funding proposal, the mental health councils played a coordinative and influential role in the State's planning and resource allocation process. In addition, the councils served as mechanisms for identifying and prioritizing community needs and spurring local agency response to these needs. Each of the 14 councils had at least one planner to provide staff support. The majority of the project applications reviewed by the councils or their designated committees pertained to grants for community mental health services, psychiatric clinics in general hospitals, and child guidance clinics. The effectiveness of the Connecticut planning system is described as "one with limited local participation in the regions and residual centralized authority in the state" (Pedersen _et_ _al_., 1973). The authors point out the alternatives as being those of centralized authority retained at the state level or of complete delegation of authority to review and fund projects vested in the regional councils, provided that each of the councils develop a regional comprehensive services plan. As they report, the "limited model of planning" currently being implemented jointly by the State and the regional councils has resulted in a limited citizen response and participation.

The New Mexico 1979-80 Mental Health Plan (Health & Environment Department, 1979) provides an indication of the concerns in that state with improvement of systematic planning for mental health services. The Plan identifies the need for continued coordination of state and local level health and mental health planning through participation in interagency committees and task forces. The Plan also delineates objectives for implementing several planning projects, including the development of a five-year financial resources plan, a proposal for an epidemiological study, and an assessment of services to special populations. Input from CMHC directors, the Chicano Mental Health

Task Force, and from representatives of the various regions of the state is one important aspect of the planning process proposed in the New Mexico State Plan.

Philosophical Basis for Planning in Texas.

Philosophy of the Texas Department of Mental Health and Mental Retardation sees mental impairment as a social problem requiring the involvement and cooperation of various public and private agencies to resolve the problem. The department espouses a philosophy in three major areas -- prevention and promotion; treatment and care; and administration and organization (Texas Department of Mental Health and Mental Retardation, 1976a).

Prevention and promotion are defined as identifying the social and personal stresses faced by high-risk individuals before major impairment occurs by providing for early detection and intervention. The treatment and care philosophy, as outlined in the 1977 State Plan, stresses the importance of focusing on a client's needs, clients' rights, high quality care, and responsiveness to community values and attitudes in the development and implementation of programs and services. The Department's philosophy regarding administration and organization includes consideration for efficiency and effectiveness of treatment, equity in service delivery to all the people of Texas, adaptability to change, compliance with all applicable laws and regulations, effective organizational structure, and coordination of services with other entities into a "human services network."

In the fall of 1974, TDMHMR held 10 intensive planning conferences which led to the development of what the Department calls the DPP -- "Dynamic Planning Process." Since that time the primary thrust of the current planning process has been deinstitutionalization -- the development of community-based services for the care, treatment, and rehabilitation of clients in the least restrictive setting (Texas Department of Mental Health and Mental Retardation, 1976a).

Texas' Dynamic Planning Process.

The Dynamic Planning Process was introduced in 1974 in TDMHMR's central administration as a result of several driving forces, both internal and external to the system, including the federal requirements for development of a State Mental Health Plan, litigation against TDMHMR regarding the adequacy of its programs and services, and problem areas identified by the department's top administrative heads (Thompson, 1980).

The new process allowed for input into planning by top level administrators, who composed a Policy Control Group, as well as mid-level administrators and technical experts on the Department's Central Administrative staff, who formed an Operations Gontrol Group. The functions of the committees, both of which operated on an ad hoc basis, were distinct: The Policy Control Group functioning primarily as an interpretative body between TDMHMR Board policies and administrative planning and programming efforts; and the Operations Control Group's major role being one of an on-going coordinative and supervisory group to insure the smooth and timely conduct of the plan development process. A third source of input into the Dynamic Planning Process was that of field personnel who served on work groups or task force committees as needed. The role of the full-time TDMHMR planning staff was a limited one during the initial development phase concerned primarily with setting policies and planning priorities, but later the planning staff were assigned the bulk of the technical aspects of writing the final planning document to be submitted to the federal government.

Despite this rather elaborate and supposedly systematic approach to planning, Thompson (1980) concludes that the actual written document, the Texas State Mental Health Plan, was essentially the work of the two TDMHMR full-time planners and that the relationship of the State Plan to the programming and operations of TDMHMR were disjointed at best. In the case of problem-solving tasks assigned to the Policy Control Group, the Operations Control Group or the informal work groups, this was not always the case, and actual implementation of recommendations was successful. But as Thompson comments, the State Plan submitted to comply with requirements of P.L. 94-63 was "shelved to gather dust until its resurrection for 'updating' the following year." His assessment, based on his four years experience as a mental health planner with TDMHMR, was that "planning ...was divorced from policy-making and budgeting" and that the "state plan itself continued to be window dressing to placate federal officials" (Thompson, 1980, p. 18).

The conflict between super-imposed directives for planning, whether at the federal, state or regional levels, and the sincere commitment to utilization of planning as a tool in service delivery continues to be problematic in the state of Texas. On the one hand, planning documents may be developed as a result of legislative or administrative mandate, but if they are not developed with implementation in mind or with serious input and thought towards making them viable guides for service delivery, then planning will continue to be a fruitless, costly, and frustrating exercise. When citizen input or a semblance of citizen participation is depicted in the planning process, but planning does not lead to implementation, citizens will feel defrauded, and planning will be seen as a subtle means of keeping the decision-making process inaccessible to the public.

As the process utilized by TDMHMR in development of a State Mental Health Plan demonstrates, cooperative problem-solving and short-term planning can be accomplished through an administrative network of policy and task-oriented committees. However, long range planning and the follow-up monitoring and evaluation necessary to interface planning with implementation in the service delivery arena is a much more difficult task to accomplish. It is perhaps one which has not seriously been attempted becuase it requires an on-going mechanism for periodic review and re-evaluation of long-term goals and plans, a mechanism which does not currently exist.

TDMHMR's Organizational Structure and its Relationship to Planning.

Several major changes have occurred in recent years in the organizational structure of the TDMHMR which impacts on the relationship between TDMHMR and community mental health centers. The organizational structure which was approved by the TDMHMR Board on February 3, 1976, includes a separate division for Program Support Services. This division was on the same level of line authority and communication with the three divisions headed respectively by the Deputy Commissioner for Mental Health Services, the Deputy Commissioners for Mental Retardation Services and the Deputy Commissioner for Community Services. The Program Support Services division consisted of four district organizational units: 1) Program Analysis and Statistical Research, 2) Standards Compliance, 3) Quality Assurance, and 4) Planning Policy Analysis. Technical assistance and system coordination with the CMHCs was the designated responsibility of the Deputy Commissioner for the Community Services.

This organizational schema was revised at the April 21, 1981, meeting of the TDMHMR Board. The four functional units under the Program Support Services division were distributed under the major staff positions (Assistant Commissioners) responsible to the TDMHMR Commissioner. A Planning and Resource Development section and a Standards Compliance and Quality Assurance section became the responsibility of the Assistant Commissioner for Internal Administration while the Program Analysis function was absorbed by the other Assistant Commissioner under the Information System Division. The responsibility for working with the CMHCs was retained in the division headed by the Deputy Commissioner for Community Services.

Two additions were made in 1978 to the State organizational structure: the appointment of a State Mental Health Advisory Council, as required by P.L. 94-63, and the designation of a State Community Mental Health Center Advisory Council. The two advisory councils both were conceived as advisory bodies to the Commissioner for TDMHMR. Although not included in the 1976 organizational chart for the Department, an eleven member Texas State Advisory Council was already in existence, with both consumer and provider members serving on it. The purpose of this council, which was established to comply with federal law, was to review and recommend revisions to the Texas State Plan and its Annual Reports, as well as review of construction grant applications (Texas Department of Mental Health and Mental Retardation, 1976a).

Content Analysis of Planning Documents, 1977-1981.

The "314(d) Plan," prepared in response to P.L. 89-749, Section 314(d) addressed four needs critical to the community mental health center movement in Texas:

1. the further development of mental health services in those areas creating organized centers;
2. the development of mental health service in rural and sparesly populated areas and areas not served by organized centers;
3. the development of a manpower program to address projected professional manpower needs; and
4. the development of a computerized data base, to be designed to serve the needs of the Community MHMR centers (Texas Department of Mental Health and Mental Retardation, 1977).

The Texas Plan for Comprehensive Mental Health Services (Texas Department of Mental Health and Mental Retardation, 1976a) was prepared to meet requirements in the provisions of Title I and Title II of P.L. 94-63. It also used as an outline the "Guidelines for the Preparation of State Plans for Comprehensive Mental Health Services," dated February 17, 1976 and prepared by NIMH. A previous State Plan had been prepared to meet the requirements of P.L. 88-164; this plan was approved by the Public Health Service on May 20, 1966. In September of 1974, the Department began a series of ten Intensive Planning Conferences to develop a base for the preparation of a Five-Year State Operating Plan, which resulted in the Dynamic Planning Process. The Texas State Plan gained full approval on October 19, 1976, after additional information was requested and supplied to Dr. Floyd A. Norman, the Region VI Administrator for the Department of HEW (Texas Department of Mental Health and Mental Retardation, 1976a). The 1978 update of the Texas Mental Health Plan makes no reference to specific planning activities aimed at meeting the needs of the Mexican American population (Texas Department of Mental Health and Mental Retardation, 1977).

The 1979 Annual Review and Progress Report (Texas Department of Mental Health and Mental Retardation, 1978a) of the Texas State Plan for Comprehensive Mental Health Services submitted by TDMHMR to comply with federal requirements contains very little substance in relation to culturally specific planning for Mexican American mental health services. TDMHMR cites two programmatic efforts, one of which is the provision of cultural and linguistic programming in the San Antonio State Hospital "Chicano Unit" which affords space for 60 inpatients. The program is available for those hospital patients whom the staff determines can benefit from the Spanish language therapy offered in the unity. The other major effort planned by TDMHMR aimed specifically at meeting the needs of a predominantly bilingual, bicultural population was the development of a Human Development Center in Laredo, Texas.

The 1980 Annual Review and Progress Report (Texas Department of Mental Health and Mental Retardation, 1979) was submitted by TDMHMR to the Regional Office of the Department of Health, Education and Welfare, as required by law for review. The Regional Administrator noted that the 1980 Progress Report prior to its approval by DHEW should include a statement from TDMHMR relating its projected activities to assure "more relevant programming for special populations" and delineating the TDMHMR's plans and efforts in the area of affirmative action (Barton, 1979).

The response of TDMHMR to these suggestions were submitted in writing to the Regional Administrator on September 13, 1979 and accepted by that office without question on September 12, 1979. In relation to programming for special populations, TDMHMR's response point primarily to the efforts of the IDRA Mental Health Research Project, which are referred to in the 1980 Progress Report, specifically a contractual agreement for two workshops to be conducted by IDRA for the 29 CMHCs in Texas on the delivery of mental health services to Blacks and Mexican Americans. Although a workshop was held by IDRA concerning service delivery issues as related to the Mexican American population, there was no agreement between IDRA and TDMHMR concerning a workshop on serving the Black population. In addition, the Progress Report's reference to a contractual agreement with IDRA for an analysis and assessment of the state mental health system's response to the needs of the bilingual/bicultural client is misleading. IDRA research activities in these areas were funded through an NIMH grant and in no way financially supported by the TDMHMR. TDMHMR did provide its cooperation in the research efforts, as did the majority of the CMHCs in Texas, and IDRA findings were widely disseminated throughout the state and community mental health system. TDMHMR's intent to utilize the research findings in its programming for special populations is pointed to in the 1980 Progress Report; however, the method by which the findings were to be incorporated into the state planning and service delivery system is never addressed in the Progress Report. In addition, specific programs for other special populations, specifically children and adolescents, is addressed in the Progress Report, but no mention is made of ongoing program efforts related to culturally relevant services for the Mexican American population. One can only conclude that no such efforts are in existence or that they are so insignificant as to merit no mention in a state mental health plan.

Mention should be made with respect to the federal role in approval of the state progress report. Although the regional administrator pointed out the need to address the issue of culturally relevant programming in the 1980 Progress Report, the gesture seems a rather symbolic one, in that the report was approved without any significant effort or documentation on the part of TDMHMR to address the issue.

The draft for the 1981 Annual Review and Progress Report (Texas Department of Mental Health and Mental Retardation, 1980) of the Texas Mental Health Plan which was adopted by the TDMHMR Board, includes in the goals and objectives the development by 1983 of "a plan for community-based services to unserved and underserved identified target populations with specific attention to minority groups" (Texas Department of Mental Health and Mental Retardation, 1980). This is the first documented evidence of TDMHMR's commitment to address the needs of minority groups in its planning process. However, no specific information is included regarding how this plan would be accomplished, who would be involved, and what the scope and nature of the plan would be.

The section of the 1981 Progress Report which contains narrative statements on the needs of special populations includes a section on the elderly, on children and adolescents, and on minorities as three distinct special population groups. The discussion of TDMHMR's efforts to address the needs of the elderly, children and youth covers programmatic matters, while the section on the needs of minority populations does nothing more than review the problems that Mexican Americans and Blacks may encounter with the current delivery system. TDMHMR offers as a response to these needs and problems the employment of a

Recruiting Specialist to strengthen its affirmative action efforts and its cooperative relationship with IDRA, which has conducted policy research on various aspects of Texas mental health system and its relationship to service delivery to Mexican Americans.

State Planning and its Relationship to Service Delivery to Mexican Americans in Texas.

One cannot say that no planning occurs in the development of state mental health services, since the state budgeting process requires budget requests to be submitted for each biennium. This requires at least a three-year foresight on the part of state administrators of the type and extent of services to be provided.

The problem lies with the method and scope of planning. The planning which occurs is a closed system, in which the public, especially minorities continue to be excluded. It is also based on an irrational process of estimation of resources, based on a reactive process rather than on projected needs; this amounts to reacting to current problems and basing future needs simply on current levels of service (Thompson, 1980). The political process also greatly affects the budgeting process from political pressures at the local level, between the state hospital and CMHC administration, within central administration staff, the LBB and state legislators.

In addition, there are no publicly stated goals which the state mental health agency is strongly committed to. The State Mental Health Plan is in essence a document which has developed a formality to meet the federal guidelines, without any real significance for the actual plans and programs which the department develops and endorses.

Thompson (1980) points out that although the state planning system and those chiefly involved with the process were committed to developing a five year plan, a fundamental commitment towards implementation of such a plan was lacking, as exemplified by the fact that the plan and the budgeting process were not coordinated and that programs were not developed consistent with the plan.

In more recent years, the State Plan developed in 1977 boasts of being the first plan which is interfaced with the state budgeting process.

The value of a written document and of an open system of planning is that goals and objectives are publicly stated and therefore more likely to be understood by the community affected. In addition, it allows the public, and especially those groups most likely to be affected, a point from which to comment and evaluate the services being offered and changes which are proposed in the service delivery system.

Although to date there have been no lawsuits addressing the specific issue of right or culturally and linguistically appropriate treatment, numerous cases which have established the client's right to treatment could in the future lead to the pursuit of similar legal bases for development of services adequate to address Hispanic mental health needs.

CHAPTER V

AN OVERVIEW OF PLANNING IN COMMUNITY MENTAL HEALTH CENTERS IN TEXAS

In an effort to assess the current status of mental health planning in the community mental health centers of Texas, a selected number of centers and their respective planning systems were studied in-depth utilizing a multi-faceted approach. The primary objectives of the research were: to describe the current level and type of planning activity being undertaken in the CMHC system in Texas; secondly, to analyze and compare the strengths and weaknesses of the various planning experiences of CMHCs in Texas; and thirdly, to assess the level of involvement and commitment of CMHCs in planning services for the Mexican American mental health client.

As has been outlined in Chapter III, there are several legislative and regulatory imperatives for CMHCs to engage in planning of mental health services. Aside from the federal mandate of P.L. 94-63 that CMHCs develop a comprehensive service plan, the State of Texas also requires in its Rules of the Commissioner (1976b) and in the Principles and Standards for CMHCs (1978b) a significant impetus for initiating planning efforts at the local level. How this challenge has been met by the CMHCs in Texas is the central issue to be discussed here.

There would seem to be ample justification for local initiative for community mental health planning given that CMHCs find themselves having to adjust more and more to providing a wide range of services with fewer and fewer resources available to them. Careful and efficient planning for the future is consistent with current trends both in corporate and human service fields, especially to improve management and resource allocation. In addition, the relative newness of most CMHCs allows for creativity and flexibility in their development, as well as the opportunity to allow citizens to assume a participatory role in its service delivery process. If community mental health centers are to truly reflect and provide for the needs of their service areas, policies and plans for the delivery of services must be carefully developed and continuously examined.

Methodology.

The study of CMHCs in Texas was conducted by reviewing several sources of information. Foremost among them is information obtained from administrators and staff of the community mental health centers themselves. Data was obtained from selected CMHCs through on-site visits to the centers and through personal and telephone interviews with executive directors, planners and other administrative staff of the centers. Table I lists the centers included in the study. A review of written documents on the CMHCs' services, planning process, and other pertinent data was the third major source of information utilized in this study.

As can be noted from the list of Table I, not all of the thirty CMHCs in Texas were included in this analysis of planning at the community level. Project limitations, including time, staff, and cost constraints, allowed researchers to include only a third of the currently operating CMHCs. Because the focus of the research was primarily to assess the impact of planning on services to the Mexican American client, several factors were examined before the centers were selected for inclusion in the study. The number and percentage of Mexican Americans in the service population of each center was considered in relation to the total Mexican American population residing in all CMHC-served areas of the state. Fourteen centers were initially selected for inclusion in this study based on this criteria (see Table II). These fourteen centers accounted for 93.1% of the Mexican American population served by CMHCs in Texas. All CMHCs included in these fourteen CMHCs served at least 20,000 Mexican Americans, and had no less than 6.0% Mexican American population in their respective service area.

Based on this selection process, it was anticipated that a fairly representative view of community mental health planning and culturally relevant service programming would be obtained from gaining an overview of the planning processes in these centers. It was later necessary to drop four centers from the study because data essential for analysis were not available. The centers dropped from this study for these reasons were: Amarillo CMHC, Gulf Coast CMHC, Harris CMHC, and Lubbock CMHC. Of these Harris County Mental Health Authority was the most significant loss, because of the size of its service area and the large Mexican American population residing in its service area.

The type of information requested from CMHCs and analyzed carefully in this research project is as follows:

1. Organizational structure of the CMHC.
2. Administrative unit responsible for planning.
3. Job description and job requirements of planning staff.
4. CMHC committees involved in planning.
5. Community involvement in the planning process.
6. Specific efforts at culturally relevant planning for the Mexican American community.
7. Process and products of short and long-range planning undertaken by the center.
8. Needs assessment methods utilized.

TABLE I

DATA-GATHERING TECHNIQUES UTILIZED IN PLANNING STUDY

CMHC	ON-SITE VISIT	DOCUMENTS REVIEW	FOLLOW-UP INTERVIEW
Austin/Travis Co.	X	X	X
Bexar Co.	X	X	X
Central Plains	X	X	X
Dallas	X	X	X
El Paso	X	X	X
Gulf Bend	X	X	X
Nueces Co.	X	X	X
Permian Basin	X	X	X
Tarrant Co.	X	X	X
Tropical Texas	X	X	X

TABLE II

Pertinent Data Utilized in Selection of CMHCs for Inclusion in Planning Study

	I	II	III	IV
CMHC	No. of Hispanics in CMHC Service Area[1]	% Hispanic in CMHC Service Area[1]	No. of Hispanics in CMHC Service Area of proportion of total Hispanic population in all CMHC Service Areas in Texas	Cumulative % of Hispanics in CMHC as proportion of total Hispanic population in all CMHC Service area in Texas
Bexar County	376,027	45.3%	23.5%	23.5%
Tropical Texas	262,572	77.8%	16.4%	39.9%
El Paso	204,349	56.9%	12.8%	52.7%
Harris County	185,715	10.7%	11.6%	64.3%
Nueces County	103,543	43.6%	6.5%	70.8%
Dallas County	88,652	6.7%	5.5%	76.3%
Lubbock County	48,532	19.1%	3.0%	79.3%
Austin/Travis County	43,899	14.9%	2.7%	82.0%
Tarrant Co.(formerly Trinity Valley)	42,960	6.0%	2.7%	84.7%
Gulf Bend	35,858	26.5%	2.2%	86.9%
Gulf Coast	31,141	11.2%	1.9%	88.8%
Central Plains	25,904	24.1%	1.6%	90.4%
Amarillo	22,513	7.6%	1.4%	91.8%

[1] Based on 1970 Census figures.

TABLE II (Continued)

Pertinent Data Utilized in Selection of CMHCs for Inclusion in Planning Study

	I	II	III	IV
CMHC	No. of Hispanics in CMHC Service Area [1]	% Hispanic in CMHC Service Area [1]	No. of Hispanics in CMHC Service Area of proportion of total Hispanic population in all CMHC Service areas in Texas	Cummulative % of Hispanics in CMHC as proportion of total Hispanic population in all CMHC Service areas in Texas
Permian Basin	20,118	12.8%	1.3%	93.1%
Central Coast	16,654	8.5%	1.0%	94.1%
Southwest Texas	13,624	4.2%	.9%	95.0%
Concho Valley	13,151	18.5%	.8%	95.8%
Heart of Texas	13,043	6.5%	.8%	96.6%
Abilene	11,257	9.2%	.7%	97.3%
Brazos Valley	10,500	8.1%	.7%	98.0%
Wichita Falls	7,121	5.8%	.4%	98.4%
Central Texas	6,972	8.3%	.4%	98.8%
Deep East Texas	4,433	1.8%	.3%	99.1%
Pecan Valley	3,566	4.0%	.2%	99.3%
Sabine Valley	3,245	1.6%	.2%	99.5%
East Texas	2,939	1.7%	.2%	99.7%

TABLE II (Continued)

Pertinent Data Utilized in Selection of CMHCs for Inclusion in Planning Study

	I	II	III	IV
CMHC	No. of Hispanics in CMHC Service Area[1]	% Hispanic in CMHC Service Area[1]	No. of Hispanics in CMHC Service Area of proportion of total Hispanic population in all CMHC Service areas in Texas	Cummulative % of Hispanics in CMHC as proportion of total Hispanic population in all CMHC Service areas in Texas
Taxoma	2,159	1.7%	.1%	99.8%
Northeast	703	0.9%	.04%	99.84%[2]
Column I Total	1,601,150			

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[2] Does not total 100% due to rounding.

TABLE III

CMHC	PLANNING DIVISION/DEPARTMENT	PRIMARY PERSON(S) RESPONSIBLE FOR PLANNING
Austin/Travis CMHC	No	Executive Director and Director of Program Evaluation
Bexar Co. CMHC	Yes	Director of Planning and Development
Central Plains CMHC	No	Director of Program Support
Dallas CMHC	Yes	Associate Director of Support Services and Director of Planning and Human Resources
El Paso CMHC	No	Executive Director
Gulf Bend CMHC	No	Executive Director
Nueces Co. CMHC	No	Executive Director
Permian Basin CMHC	No	Executive Director
Tarrant Co. CMHC	No	Quality Assurance Administrator
Tropical Texas CMHC	Yes	Director of Planning Division

9. Implementation and evaluation monitoring of planning processes.

10. Relationship to other planning entities, i.e. TDMHMR Planning Division, Health Systems Agency planning, and other human service planning bodies.

Planning Policy.

Very few CMHCs contacted had formalized policies concerning the philosophy, process or operation of a planning process. Planning in most CMHCs was conducted in an informal manner, at the initiative of either the Board of Trustees or the chief administrator for the center. Planning of services for the Mexican American client was not a formalized activity either, if it existed at all. There were several centers which did have Board of Trustees approved policy concerning planning. Among them was Dallas CMHC, whose board of trustees had approved a policy in 1977 that the center be managed and operated according to the long-range and short-range goals adopted in the center's plan. This plan was to receive annual review and periodic revision as necessary. Tropical Texas CMHC recently adopted a policy for FY 1980, which states that the center staff will "develop long range plans which will identify the service needs and estimates of resources... and will, at least annually, thereafter revise such plans." (Tropical Texas CMHC, 1979). The Tropical Texas policies also include provisions for community input into planning by requiring at least annually that a survey of clients and their families be conducted; a public hearing at least once a year on the center's goals and priorities is also provided for in the policies. Tropical Texas CMHC has also adopted an elaborate Grants/Contract Synopsis system, which is a system of both grants management and delineation and monitoring of program goals and objectives. Although other centers do not have a formal policy regarding the conduct and implementation of planning, executive directors in centers such as El Paso, Nueces County, and Bexar County CMHCs have established administrative procedures regarding planning, in most cases involving program manager input into annual work sessions to develop long or short range planning concepts, which in some cases are presented to the Board of Trustees of the CMHC. In Tarrant County CMHC, planning activities have received board sanction and proceeded according to the directives of an ad hoc advisory committee for planning. Other centers, such as Gulf Bend CMHC and Permian Basin CMHC, have relied primarily on the state's requirements for zero-based budgeting in lieu of any locally devised planning or goal development policy.

Policies relating to planning culturally sepcific and linguistically appropriate services to Mexican American mental health clients are virtually non-existent, with the exception of very general policy such as the following incorporated by Tropical Texas CMHC Board of Trustees in its Philosophy of Care policy: "The Center shall take into account social, cultural, and economic factors of the population when planning, developing, and operating services" (Tropical Texas CMHC, 1979). Within the five year plan adopted by Bexar County CMHC is a goal to establish programs to address the needs of minorities and other special populations. El Paso CMHC, according to its Executive Director, focuses its planning towards the majority population in its service area, which is primarily Mexican American. However, the majority of the CMHCS s included in this study had no policy for planning of services to the Mexican American population in their community.

The Structure for Planning.

The results of the research conducted showed that commitment to the planning process varied considerably in the CMHCs contacted. Only three of the CMHCs contacted had a planning division established and a full-time planner as a permanent staff position. However, those CMHCs that did have planning staff tended to have the position as a top level administrative function or assigned to one of the chief administrative heads of the organization. As shown in Table III, planning at the community mental health centers was usually a function described as the role of the executive director of the agency, often with the program managers of the organization contributing their input through staff meetings. However, most of the planning done in this manner consisted of operations planning directed at preparation of the biennial budget requests and did not encompass long-range planning for the overall goals and programs of the CMHCs.

Very few of the community mental health centers included in the study had written requirements or policies sanctioned by the Board of Trustees which related to the planning function. In fact board policies related to planning were found in only four centers' policy manuals. One of those was Dallas CMHC, which had the following approved policy: "The center shall be managed in such a manner as to achieve long and short range goals and objectives according to a plan adopted by the Board, reviewed annually and revised as appropriate. The evaluation of Center activities will be accomplished through documentation of the achievement of goals and objectives stated in the plan" (Dallas CMHC, 1978). The goals of the Dallas CMHC which are delineated in board policy include conducting a needs assessment as a goal. A major role of the Board is "strategic planning" according to adopted policy of the CMHC. Involvement of the community in planning is required through participation on the Professional Advisory Committee, whose tasks include identification on needed services and program planning, and by participation on the Citizen Advisory Committee, which also assists center staff in the identification of needed services.

The policies of Tropical Texas CMHC regarding planning require that "in order to assure that treatment programs are developed which meet the needs of the community served, each new program considered will begin with a community survey or assessment of need" (Tropical Texas CMHC, 1979). Its policy for long range planning states that a long range plan be developed during fiscal year 1980, to be revised at least annually thereafter, and to be approved by the Board of Trustees of the agency. A specific outline for assessing community needs and obtaining community input is outlined in another Tropical Texas policy. This policy requires the CMHC staff to utilize advisory committees, human service agency personnel, public hearings, and client surveys at least annually as methods to obtain information concerning mental health needs of the area.

Permian Basin CMHC's Board of Trustees has adopted the following policy regarding planning: "The centers shall write a comprehensive service plan at least annually which shall reflect the catchment area's changing needs, technologies, and resources" ...and the comprehensive service plan shall be ...approved by the Board of Trustees (Permian Basin CMHC, 1978). The procedures accompanying this policy which are contained in the Board policy manual follows closely the TDMHMR requirements for a comprehensive service plan and ZBB format. In contrast Central Plains CMHC has board-approved planning policy which merely defines the center's philosophy of planning as "rational planning to meet the mental health needs of the community in that input from citizens is coupled with professional input to determine these needs" (Central Plains CMHC, 1978).

The lack of board initiative in mental health planning is substantiated by those CMHC representatives interviewed. With the exception of Nueces County CMHC and Tarrant County CMHC, all other CMHCs' planning activities were conducted as a result of directives from the executive director of the center. In Tarrant County and Nueces County, the planning process was initiated as a result of TDMHMR's request that the centers develop a long range plan (a document other than the biennial zero-based budgeting document).

Overall the research conducted shows that the planning efforts among CMHCs in Texas are of an informal, loosely structured nature. There is little uniformity in the way the planning function is defined, organized or implemented, and in most of the centers studied, planning is an on-going function of the center. TDMHMR seems to have little impact on whether planning exists as a integrated and operational component in the CMHCs, despite federal legislative requirements and its own guidelines regarding the maintenance of comprehensive services planning by CMHCs.

The Nature of Planning at the CMHCs.

The type of planning being undertaken by CMHCs in Texas varies as much as the commitment and rationale given for its existence. As described in Chapter II, planning can take on many different forms depending on its purpose and definition.

The primary type of planning that is undertaken at most CMHCs at the present time is budgetary planning required under the state of Texas' biennial funding process. Identifying funding needs and priorities are essential to the survival of the center Budgetary planning is also a highly regulated activity, with very specific procedures developed by TDMHMR and federal funding agencies which the CMHC is expected to follow. Many CMHC administrators combine the function of budgetary planning with the notion of short range planning, although the activities undertaken may well be the simple formalizing into written form the objectives of current programs. A major problem of the current process is that although short range objectives may be developed in order to accommodate requirements of the biennial budgetary reporting process, the development of these objectives is often not the product of what can be called a planning process. In most cases these short-range objectives for programs are not reviewed or revised each; rather they remain static. Very often the goals or objectives are not based on a needs assessment process or related to long-range goals of the organization. The data base to support these program objectives is seldom based needs but rather on utilization data. Thus what is considered short-range planning is not a projection of needed resources and programs in the near future, but rather a justification for continuation of the current programs.

Data collection and analysis is one of the most frequently reported planning activities being conducted by centers. Primarily data reporting to the TDMHMR Management Information Division is the reason for the investment of time and staff in this activity. In addition, data is a primary method used of depicting to funding agencies and local boards and advisory committees of the center's effectiveness in carrying out its purpose, the delivery of services to its clients. In essence it represents CMHC's method of providing accountability, both externally and internally, in its own administrative evaluation process. However, in the majority of cases, the data being collected is limited to describing the center's and staff's activities, and seldom includes any effort at assessing actual effectiveness or impact of the center's programs on the client population or the mental health problems of the area. For this reason, it is difficult to obtain from the current data bases being maintained at these CMHCs, data that can contribute to assessing future needs of their services area. In terms of data which can be utilized for evaluation, data being gathered is geared at process evaluation rather than outcome evaluation.

Long-range planning at the CMHCs selected for the study is more the exception than the rule. However, among those CMHCs which have attempted to conduct long-range planning, there are several approaches which have been utilized and results obtained have been distinct in these cases. Because each CMHC which has undertaken long-range planning presents a unique experience, a brief summary of their respective planning systems are presented in the second half of this chapter. A synopsis of long-range planning being conducted by Bexar County CMHC, Tarrant County CMHC, Tropical Texas CMHC, and the Dallas County CMHC is described and analyzed.

Relationship with Other Planning Functions.

Planning activities being conducted by CMHCs interviewed through this study demonstate that although there is close working relationship with TDMHMR in development of input information for the biennial budget request, there is little understanding of the actual process by which the final funding request is made to the Legislature. As one administrator commented, the CMHCs prepare their budget requests and ZBB based on what they think the Legislature will accept or will fund, but often find that there is no rational process by which one can understand how the TDMHMR's budget request to the Legislature nor the Legislature's final approved budget package is developed.

While the budgeting process requires close interaction with the TDMHMR Central Administration, in the development of the State Mental Health Plan, there is little opportunity for input, according to those interviewed, in the development and review of the Plan. The Plan does not reflect community needs since it is developed for the most part from a top-down approach, whereby statewide needs are derived by the TDMHMR administrators, and local centers are expected to incorporate statewide needs in their planning endeavors. Thus, regional differences are not often taken into account and indeed would seem hard to incorporate in such a statewide planning process. Most of the administrators and planners interviewed stated that, aside from the client data submitted to TDMHMR on a regular basis, their only other input into the process was through a review process which occurred after the document had been developed and was in the process of approval by the TDMHMR Board.

The relationship of most CMHCs with the Health Systems Agency in their service area was one of cooperation, in providing information and input to each other. Several CMHCs commented that they were the sole contributors to the development of the HSA mental health goals for their service area, while others stated that they were invited to participate as members in advisory committees developing the goals for their areas. Because of the current projected dismantling of the HSA planning system, inquiries were posed to the administrators and planners contacted regarding the future of health planning and its impact on their respective CMHC. Few commented that the impact would be of significance for their center, and several commented that the regional planning body, the Council of Governments for their area, would likely fill the vacuum, given their previous experience in comprehensive health planning.

A SYNOPSIS OF THE PLANNING PROCESS IN TWO CMHCS

The planning efforts of two community mental health centers are described below. The planning processes of these two centers were chosen to exemplify extensive efforts at long range planning for their service area. Only two other centers have demonstrated initiatives in long range planning: Tropical Texas CMHC and Dallas County CMHC. The planning process at the Dallas CMHC is still in its initial stages and therefore it is difficult to report on its progress since the process can only be described as intentions towards long-range planning. Tropical Texas CMHC has meshed its planning process with its grants management system.

Bexar County CMHC.

The organizational structure of the Bexar County CMHC consists of three administrative directors: an assistant executive director who is responsible for administration of the agency's programs, and six staff advisory administrators of which the Director of Planning and Development is one. The agency's service programs under the authority of the Assistant Executive Director, are assigned to five program managers who supervise the following areas: 1) Southeast Mental Health Program; 2) Southwest Mental Health Program; 3) the Mental Retardation Program; 4) the Drug Dependence Program and Alcohol Treatment Program; and 5) Centerwide Services Program. Responsibility for planning falls within the scope of duties of the Director of Planning and Development. As the planner and grants manager for the agency, the Director of Planning and Development reports directly to the Executive Director and solicits cooperation from the agency's administrative heads and program personnel in the formulation and implementation of plans. The Director of Planning and Development has had no staff support for the past three years, so that reliance on the input, assistance, and time investment of program managers in the planning process is essential.

The current planner at Bexar County CMHC has been involved in planning services at the center almost continuously since 1972, when he was first hired to plan and develop the Southwest Mental Health Program. Previous experience of the planner included work with the Model Cities Program and the Mexican American Unity Council in San Antonio. One of the advantages of the planner at Bexar County CMHC was his knowledge and previous experience in working with individuals, both grassroots and agency professionals of the San Antonio area. In particular, familiarity with the areas in which program planning and development were on-going was an asset in encouraging community involvement in planning and utilization of programs. Duties of the Director of Planning and Development include coordination of all grants, technical reviews, grants management, contract and reporting for all grants as well as participation in preparing the state budgeting reports, workload measures and MBO system requirements of TDMHMR.

According to the Director of Planning and Development, all advisory committees to the agency are used as resources in the center's planning; these committees are the mental health, substance abuse, and mental retardation advisory committees. Advisory committees were first established at Bexar County CMHC in 1970, not long after the establishment of the CMHC, in anticipation of federal requirements that CMHCs create such mechanisms for community input.

The planning process utilized in developing the Southwest Mental Health Progam served as a model program planning effort for Bexar County CMHC. A staff member was hired as a planner and community organizer to develop the program. The planner organized an ad hoc advisory committee of professional, grassroots, and social agency representatives at the inception of the process. The planner organized a series of community meetings over a six month period throughout the projected service area (Southwest San Antonio) in such diverse locations as churches, schools, community halls, civic meeting places, and social service agencies. The purpose of the meetings was threefold: to educate the community about the potential services which could be offered by Bexar County MHMR, to obtain input from the community regarding their most pressing needs and concerns, and to solicit community support for the program. Housing, child abuse, substance abuse, paint sniffing, unemployment were among the major concerns that individuals at the hearings identified as areas of stress for family, community, and individuals of the area. Advisory committee members were utilized as liaisons with residents of specific targeted neighborhoods and blocks in order to assess needs and encourage involvement.

Bexar County MHMR developed a long-range plan several years ago as a result of administrative initiative on the part of the Executive Director of the agency. The plan covered the period fiscal year 1979 through fiscal year 1983 and addressed a variety of service components, including mental health services, mental retardation services, alcohol and drug abuse services. This five year plan was developed as an ideal services plan, which identified those services, programs, and goals which the CMHC should implement or continue to implement in future years. Some of the goals have been brought to fruition, while others have not yet been met, partially because they were deemed unrealistic to accomplish given the resources of the CMHC or the changing pattern of funding available to the center. There have also been changes in program priorities which have since occurred, although not reflected in a documented revision of the plan.

The process used in development of the plan included a one and one-half day retreat of the advisory committees, board of trustees members, and administrative staff with the planner of the agency. At this meeting the planning staff presented information regarding legislative requirements, census data, and center statistical information which could be considered in development of long-range goals and objectives of the agency.

The conference held included representatives of other agencies as well. The format included a general session, in which Board, administrators, advisory committee all participated. Approximately 70% of the participants were Mexican American. The planner provided a general orientation, prior to group sessions in substantive areas such as mental retardation, mental health, and substance abuse. Smaller work sessions approached various aspects of each program area, include outpatient, inpatient services. A staff member knowledgeable about resources, legislation, funding needs, data, and state requirements was available to each task force concentrating on these work sessions.

The retreat sessions served to identified a wide spectrum of all inclusive needs and goals for the CMHC to accomplish. Staff then worked on preparing written objectives consistent with the needs and goals identified, and cross-referenced and compared these to the goals, objectives and service requirements of TDMHMR, AACOG, HSA, and the state and national legislation, and to previously established Board of Trustees goals.

Needs assessment for the long-range plan was based on several factors: data derived from a variety of sources; identified goals and needs in the HSA, AACOG, and TDMHMR planning processes; and information from various organizations which had conducted mental health studies. Data included what AACOG had developed in terms of needs, goals and statistics for the area. It also took into account what HSA planners were doing. Most statistics utilized however were based on TDMHMR data and on studies made by the National Association of Social Workers, American Psychiatric Association, and other such sources. Two local needs assessments were utilized as resource information.

AACOG had conducted local needs assessment of social service agencies, primarily to identify services which were being provided, unmet service needs, target populations and groups being turned away from services at the current time. The Model Cities needs assessment conducted in the early 1970s on drug abuse and mental health services in San Antonio was also consulted.

A primary source of data on mental health needs was the standard risk factors, social indicators, lifestyle stress factors such as population mobility, size of the migrant population, alcoholism rates from state hospital admissions and other state hospital client data. Information on the needs of the Mexican American population was available only in a few instances, and most of the information on needs, risk factors, etc. was for the general population. However, because of the population distribution in various quadrants of the services area, where there were high concentrations of Mexican Americans, extrapolations could be made on certain data.

A revision of the five year plan was inititated in 1979, but the revisions proposed by the Planning Department have been shelved indefinitely, awaiting the outcome of funding changes to be made by the Reagan Administration before submission of the plan's revisions for Board approval. The instability of programs and funding sources experienced by Bexar County CMHC has had the effect of halting the long-range planning process.

Goal statements were adopted by the Board, based on general goals developed by TDMHMR. Although impetus for long-range planning at Bexar County CMHC was locally initiated, P.L. 94-63, gave added strength to the need to continue the process. The long-range planning process for Bexar County was begun in early 1978, but not completed until late 1978, to begin to take effect in September 1978, beginning with the Fisal year 1979.

The revised five-year plan has not been approved by the Board and is not likely to be submitted for Board approval because of the instability of the current situation. The revised plan, however, has been developed primarily through a different method than the original one in which there was extensive board, advisory committee and outside involvement. The current revisions were primarily a result of program unit input from managers and other CMHC staff.

In the past long-range planning was carried out with a reasonable assurance of amounts and type of financial support might be expected from the federal and state government; Bexar County CMHC, like other CMHCs now faces the reality of identifying other funding sources which may be tapped for their programs in order to prevent a reduction in the services it provides.

Tarrant County CMHC.

The long-range planning process at Tarrant County CMHC began in Spring 1977 as a result of a reorganization of the governance and organizational structure of the center. At that time TDMHMR required from the CMHC a long-range plan within 90 days of the reorganization, thus invoking Rule .002 that newly established centers file a long-range plan with the Department. Although the 90-day period was not adequate time to develop a long-range plan, a report (Phase I Report) prepared to meet the requirements was submitted containing demographic data, a history of the CMHC, and priority rankings for services. The CMHC never received a response from TDMHMR regarding the acceptability of the document, thus it was felt that it was merely a formality that was being required by TDMHMR. TDMHMR adminstrators were aware of the continued process undertaken by the Tarrant CMHC to develop a Phase II report, which would actually attempt to address long-range goals of the center; at times TDMHMR representatives even participated in the meetings held but never expected that the planning document developed actually replace what had previously been submitted.

An ad hoc advisory committee was formed by the Board of Trustees to develop the long-range plan required by TDMHMR and continued their work for one and one half years in an attempt to develop a viable and comprehensive long-range plan for the center.

The Final Report (Phase II Report) was completed in 1979. At that time it was expected that planning would continue, with the next step to develop goals and objectives, but the process was discontinued when dissension among committee members led to the tabling of further work of the committee.

Board involvement throughout the planning process was minimal, although it did give final approval to the Phase II Report produced by the Planning Advisory Group. It did not provide, however, guidelines for the Group or guidance as to what should be developed in the way of a plan.

The Phase II Report, as the comprehensive plan was called, was not a complete but rather a comprehensive needs assessment and a preliminary examination of priority statements. The recommendations to the Board of Trustees in the report included a statement that it was the authority and function of the Board to develop goal statements from the information presented by the advisory committee. Once the Phase II Report was completed, long-range planning at the center was set aside, although individual board members did refer to the priority statements in their deliberations.

Long-range planning are getting underway again with the reorganization and reactivation of the planning advisory group to the Board of Trustees. The Planning Group is again to be staffed by the Quality Assurance Administrator of the CMHC as in the previous planning cycle. The current Chairperson of the Board of

Trustees, previously the chairperson of the Planning Control group, has been the major force in reactivating the long-range planning process; she sees the process as a means of keeping the CMHC in tune with the community and also involved with the other agencies in the human service network.

Plans for future long-range planning activities are an attempt to blend the community forum approach or model of planning previously utilized with the "expert" or rational planning approach used by the United Way of Tarrant County. The United Way will be more involved in the advisory committee's work this cycle, with the several professional planners currently on their staff serving as resource persons to the CMHC's planning process.

One of the weaknesses of the long-range process undertaken was that there was not significant participation of grass roots individuals and persons not knowledgeable or connected with the mental health system in some way. This was felt to be unrealistic expectation. Another weakness was that planning was never defined, and that the issue of whether the CMHC should be planning for the entire service community or only for its own services was never really resolved. The agency was never able to invest financially in the planning process and continues to contend that planning is an activity it cannot afford.

The major strengths of the process were that it was a mechanism for taking the pulse of the advocacy and human service network, while at the same time serving as a training ground for advocates, increasing their knowledge of the political and legislative process.

CHAPTER VI

MEXICAN AMERICAN MENTAL HEALTH PLANNING: A GOAL FOR THE FUTURE

From this author's study of the planning process as it currently exists in the various mental health agencies of Texas, it is evident that planning is a marginal function at best in the majority of these agencies. Planning of services for the Mexican American, as a special population group with distinct mental health needs and problems, is a rarity. Consideration is given in a few CMHCs to the importance of staff development and staff recruitment efforts which will enhance the CMHC's ability to meet Mexican American service needs, but there is no systematic and continuous approach to the task. Planning as a method to analyze, improve and innovate in the provision of appropriate and quality mental health services to Mexican Americans is not being utilized in most CMHCs.

This is largely due to the fact that planning as an activity is fairly new to the mental health system, and indeed in many CMHCs has not yet crystallized. Minimal activities are conducted in the name of planning in order to satisfy requirements of the state zero-based budgeting system and to meet federal funding requirements for written documentation of planning. Most CMHCs do not have a formalized system for identifying community mental health needs and goals and to assure the implementation of applicable service programs. Programs are developed based on a reactive approach to problems which arise from informal consideration of the issues involved. Very often programs are implemented without a thorough study of how the services to be provided fit into the overall purpose and goals of the community or the agency. The overriding consideration in the development (and so called "planning") of programs at the present time is not the need for the program nor its compatibility with the service population, but rather the availability of funds to implement such a program. This is exacerbated by federal mandates to provide a wide range of services, without adequate support to ensure that services provided are designed and planned for the specific population group to be served. In fact a major complaint of administrators contacted in this study was that the continuing reduction in federal support for community mental health services would lead to further diminishing the CMHCs' planning components. Several CMHCs have already reduced their planning staff and others which did not have a planner position do not foresee hiring one in the future. Local commitment to the importance of planning as a tool for development of the center and its services has not been realized. Although many CMHC directors and board members acknowledge the need to plan, planning is still seen as an optional component in the administrative structure of an organization; one of the first to go when funding limitations require cutbacks in administration expenditures.

As the study undertaken documents, community mental health planning at the current time is primarily limited to compliance with the TDMHMR's zero-based budgeting requirements, which consist of outlining services provided by the centers and the goals and budget requirements of these services. Long-range planning of five years or more is not being required by TDMHMR or by CMHC boards of trustees, with a few exceptions. Few centers are conducting their own needs assessments, either of the general community or special population subgroups such as the Mexican American mental health client. Social indicator data are gathered and utilized primarily as justification for current programs and evaluation of their effectiveness. State mental health planning, as compiled into an annual TDMHMR planning document, is essentially a compliance document, developed to meet federal planning requirements. Regrettably, mental health administrators in Texas admit that the efforts at long range planning conducted by the TDMHMR and a handful of CMHCs remain in the realm of unimplemented planning documents, which are reviewed periodically and reshelved.

As the author has tried to point out, planning requires that service providers map out what service delivery will be like before implementation of a program. It entails careful consideration of goals and alternatives. The true test of thorough and effective planning is the translation of planning into services provided to clients. When little or no planning occurs, as have been documented by this research, services may develop haphazardly and with little consideration of ethnic and cultural issues. Planning can be a seed which will blossom into a needed, productive and appropriate service, but if converted into a means of budget justification, it can also be a futile, wasteful process. Essentially one can claim to be conducting planning when in reality it is a rationalization process for current activities which have not been carefully planned and considered.

Despite the lack of implementation of major planning projects in most CMHCs, those centers which have made initial attempts have gained immeasurably by the community participation they have been able to arouse. Ultimately, the greater participation and support gained by CMHCs in planning can be a positive factor in making important decisions for the development of mental health services in the respective area. In addition, it will strengthen the organization's evaluation and accountability functions. Irrespective of these positive gains that can be achieved through greater participation in planning, especially through the use of community input, many mental health administrators view planning as loss of control, as well as a time-consuming and costly endeavor.

One of the contributing factors to the lack of culturally relevant mental health planning and programming for the Mexican American population of Texas is the absence of a state initiative for monitoring local CMHCs' efforts in this direction, even in localities with high concentrations of Mexican Americans. The state mental health authority has not provided leadership in the development of innovative, appropriate services for this special population group, nor has it met its responsibility to evaluate mental health planning to ensure that Mexican American service needs are considered. In addition, federal adminstrative monitoring in this area has proved ineffective and consists of little more than a superficial review. Perhaps the efforts of the federal and state mental health bureaucracies have been to assess CMHCs' intent to plan rather than whether actual planning occurs or whether written plans are ever implemented. In summary, planning and development of goals to meet Mexican American service needs has yet to materialize.

The research conducted demonstrated that very little planning is taking place to develop services specifically appropriate and compatible with Mexican American linguistic and cultural characteristics. At the state level, the state plans are developed with very little participation from Mexican American mental health experts or advocates, and this is reflected in the superficial way in which culturally relevant programming is addressed in these plans. The isolated example of planning aimed at the needs of Mexican Americans in Texas is the Chicano Unit of the San Antonio State Hospital, a program with a 60-patient capacity. Although the Texas Department of Mental Health and Mental Retardation requires that CMHCs provide culturally and linguistically appropriate services, there is no evidence that TDMHMR administrators monitor compliance with their own requirements.

Mexican American participation in the mental health planning process has for the most part been limited. Participation through the internal structures for planning has been limited by the underrepresentation and in some cases exclusion of Mexican Americans at decision-making levels in the existing mental health centers. There have been attempts by Mexican American advocates to provide a framework for culturally relevant planning and to develop plans outlining needs and goals to address mental health issues affecting the Mexican American population. These have been general in scope and developed with a broad perspective which needs refinement at the programming level by each local CMHC.

The planning arena has the potential of allowing Mexican Americans access into and significant input into the direction and shape that mental health services will take in the years to come. The community mental health system stands to gain from encouraging Mexican American participation in the development of programs and services to meet their specific needs and problems. Several avenues for Mexican American participation in the planning system could be explored and utilized: surveying Mexican American community members as part of an overall needs assessment project; appointment of Mexican Americans to serve on boards and advisory committees engaged in the planning process; hiring more Mexican Americans to staff high level planning and administrative positions; conducting community hearings in Mexican American neighborhoods; and involving Mexican American community leaders or representatives in the goal-setting process of the CMHC. These are only a few ways which could enhance efforts to effectively serve Mexican American mental health needs. The creativity and commitment of CMHC administrators and board members will determine whether these and other ways are sought to improve mental health service delivery to Mexican Americans.

One thing seems certain, the less overall planning that a community mental health center engages in, the less likely that planning will be utilized as a tool to address Mexican American service needs. One can clearly see that future planning efforts, if they are to effectively address issues of importance to the implemenation of culturally and linguistically relevant services, will require more than federal legislation. State and federal commitment to implementing such laws, local initiative in planning, and Mexican American community leverage will also be needed to bring the goal of Mexican American mental health planning to fruition.

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